

MEDICARE SPENDING AND FINANCING

A PRIMER

2011

MEDICARE SPENDING AND FINANCING

A PRIMER

FEBRUARY 2011

Prepared by:

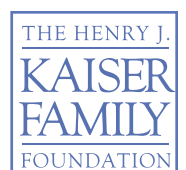
Lisa Potetz

Health Policy Alternatives, Inc.

and

Juliette Cubanski and Tricia Neuman

The Henry J. Kaiser Family Foundation



A PRIMER ON MEDICARE SPENDING AND FINANCING

INTRODUCTION

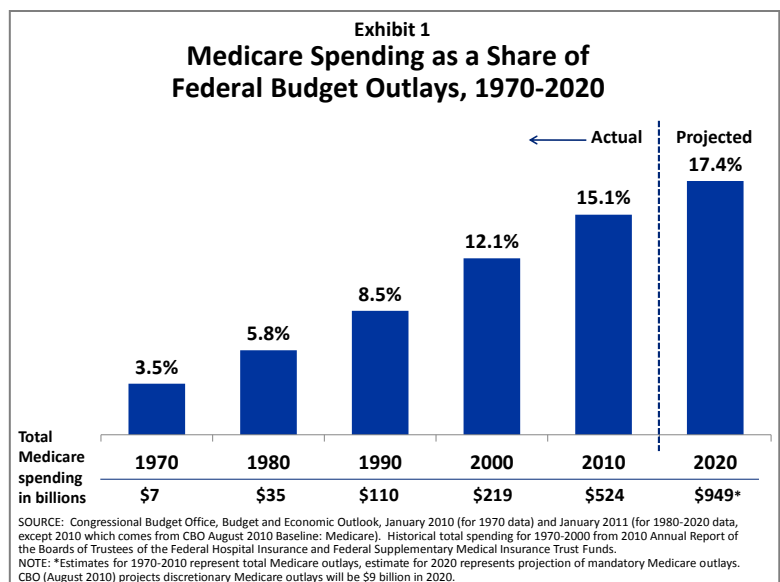
For 45 years, Medicare has successfully provided access to health care services for the elderly ages 65 and over and many nonelderly people with disabilities, and currently covers 47 million Americans. Persistently high rates of growth in national health expenditures combined with demographic trends, however, pose a serious challenge to the financing of Medicare in the 21st century. This paper provides a detailed overview of Medicare spending and financing, beginning with a review of the factors contributing to the growth in Medicare spending, including the effects of the 2010 health reform law. Next, it explains the structure of the Medicare program's financing, reviews various measures of fiscal status, and discusses the expected effects of rising Medicare costs on beneficiaries. The paper concludes with a discussion of the program's long-run financial challenges.

With Medicare being the nation's single largest health insurance program covering a large population for a broad range of health services, the program's influence extends well beyond the assistance it provides to its beneficiaries. Medicare expenditures and the policies under which the program operates have a large impact on the nation's health care system. One in five dollars used to purchase health services in 2008 came through the Medicare program, which finances nearly four in ten hospital stays nationally.¹

TRENDS IN MEDICARE SPENDING

Since its enactment in 1965, spending on Medicare has grown steadily, as measured in absolute dollars, as a share of the federal budget, and as a share of the gross domestic product (GDP), and these trends are expected to continue (**Exhibits 1 and 2**). In fiscal year 2010, Medicare's \$524 billion in total expenditures represented 15 percent of all federal outlays, exceeded only by Social Security benefits and defense spending, which each accounted for 20 percent (**Exhibit 3**).² By 2020, Medicare is projected to reach 17 percent of budget outlays and 4 percent of the GDP.

Between 1985 and 2009, growth in Medicare spending averaged almost 9 percent annually, compared with 5 percent growth in both the GDP and medical care inflation during those years (**Exhibit 4**). The average annual growth in aggregate Medicare spending (9 percent) exceeds the average growth in Medicare per capita spending (7 percent) during this period because it includes costs attributable to the growth in the

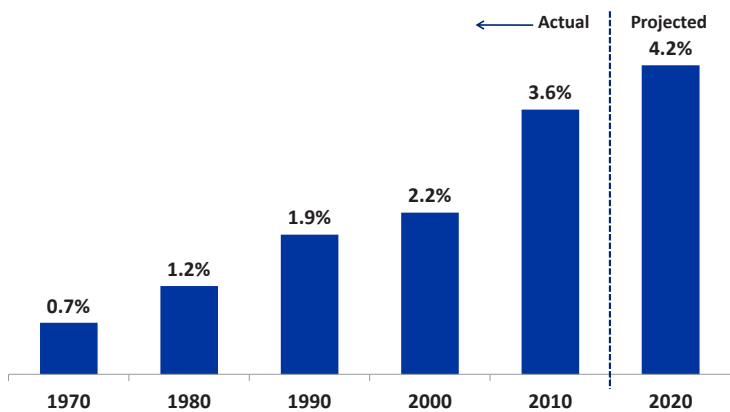


Medicare population, which increased by almost 2 percent annually during this period. The addition of the Part D prescription drug benefit in 2006 contributed to the rate of growth; excluding Part D, average annual Medicare growth in total spending was just under 8 percent overall and 6 percent per enrollee.

Looking to the decade ahead, Medicare spending is projected to grow more slowly (about 6 percent annually), and on a per-beneficiary basis, will be closer to growth in GDP and general inflation.³ However, current projections of Medicare spending also assume large cuts in physician fees that will occur under current law due to the physician payment formula known as the Sustainable Growth Rate (SGR). If reductions in physician fees are avoided in the future, as they have been numerous times in recent years, Medicare spending will exceed the current projections. For example, under one alternative scenario, the Medicare actuaries estimate that Medicare spending could be about 9 percent higher in 2019 than it is projected to be under current law.⁴

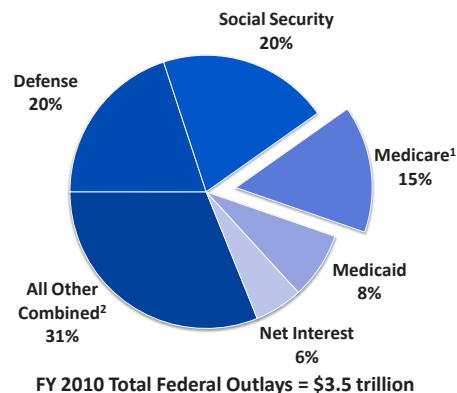
Medicare spending growth generally reflects trends in national health spending, which for many years has outpaced growth in the economy, rising from 7 percent of GDP in 1970 to nearly 18 percent in 2009, and is projected to reach 20 percent by the end of the decade.⁵ Over the long run, average growth in Medicare spending per beneficiary has been slightly lower than per capita growth in private health spending for comparable benefits, although over some periods of time the opposite has been true (**Exhibit 5**).

Exhibit 2
Medicare Spending as a Share of Gross Domestic Product (GDP), 1970-2020



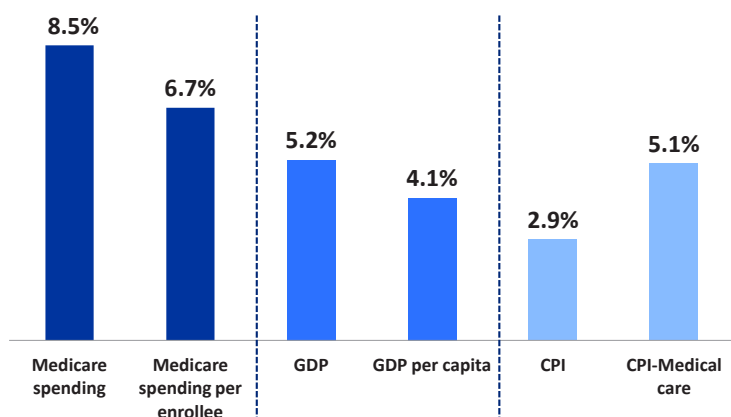
SOURCE: Congressional Budget Office, Budget and Economic Outlook, January 2010 (for 1970 data) and January 2011 (for 1980-2020 data).

Exhibit 3
Medicare Spending as a Share of Total Federal Outlays, FY 2010



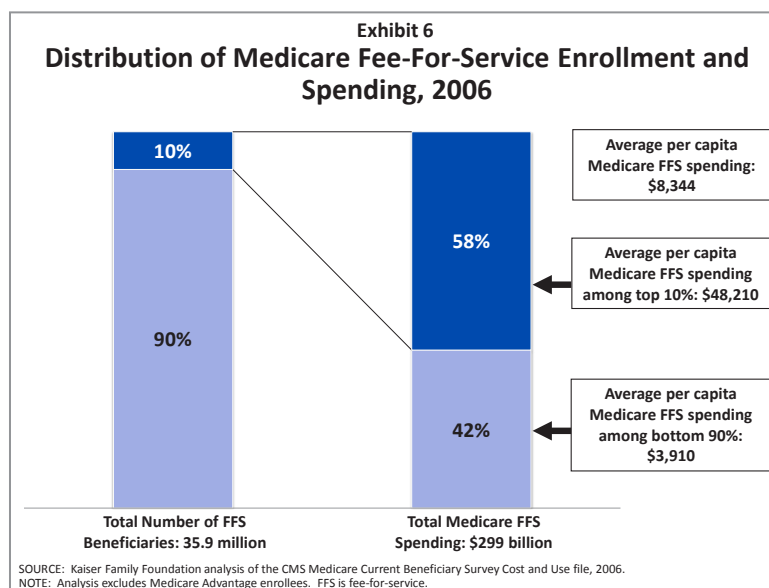
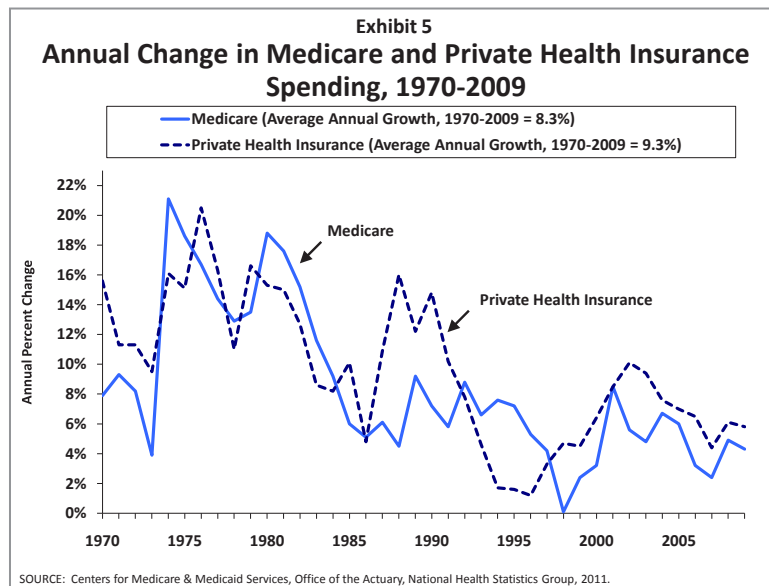
SOURCE: Kaiser Family Foundation based from Congressional Budget Office, Historical Budget Data, January 2011.
NOTE: FY is fiscal year. ¹Amount for Medicare is mandatory spending and excludes offsetting premium receipts (premiums paid by beneficiaries, amounts paid to providers and later recovered, and state contribution (clawback) payments to Medicare Part D). ²All Other Combined category includes other mandatory outlays, offsetting receipts, and negative outlays for Troubled Asset Relief Program.

Exhibit 4
Average Annual Growth in Medicare Spending, 1985-2009
Compared with Economic Benchmarks



SOURCE: Economic Report of the President, 2010, except Medicare data from the 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.
NOTE: GDP is gross domestic product. CPI is consumer price index.

The distribution of Medicare spending across beneficiaries has been and continues to be highly skewed, as is health spending for the broader population. In any given year, a relatively small share of the Medicare population, ten percent, accounts for a majority (58 percent) of all Medicare spending (**Exhibit 6**). Average Medicare spending for beneficiaries who are in the top ten percent of the Medicare population (\$48,210) was nearly six times greater than the average across all beneficiaries in 2006 (\$8,344).



WHAT FACTORS CONTRIBUTE TO GROWTH IN MEDICARE SPENDING?

The Medicare actuaries have identified a number of factors that increase health care costs, including those paid for by Medicare, Medicaid, and private health insurance. Specifically, these are increases in the prices paid per service and increases in the volume and complexity of services provided per beneficiary. Medicare costs are also affected by growing program enrollment and an aging population, along with other factors that are unique to the Medicare program.

Prices, Volume, and Complexity of Services

The rates Medicare pays for specific services are generally indexed to reflect inflation in the prices of goods and services used to produce those services. For example, hospital payment rates are tied to changes in the price of a “market basket” of goods and services that hospitals must purchase, including wages and benefits paid to nurses and other employees, drugs, food, and medical equipment and instruments. In addition to prices, medical advances and other changes in the practice of medicine over time have increased the average volume and intensity of the services provided to Medicare beneficiaries. Together, these effects have increased program expenditures over time and are expected to continue to do so in the future.

Increased Enrollment and an Aging Population

Often discussed as a driver of Medicare spending is the accelerating growth in program enrollment that will occur with the retirement of the post-World War II “baby boom” generation, who began to turn 65 in 2011. Between 1995 and 2009, as the cohort of individuals born during the Great Depression and World War II became eligible for benefits, Medicare enrollment grew by an average of 623,000 beneficiaries annually. Looking to the future, net Medicare enrollment growth is expected to average more than 1.6 million beneficiaries annually between 2010 and 2030, and the program will reach a total of 80 million enrollees in 2030 – double the number of enrollees in 2000.⁶

The contribution of increased enrollment and an aging population to growing Medicare spending, however, is modest relative to the effects of rising health care costs. CBO projects that increased program enrollment along with the aging of the Medicare population will increase Medicare spending from 4 percent of GDP in 2020 to 5 percent of GDP by 2035; however, when all factors affecting Medicare and rising health care costs are also included, Medicare spending is projected to rise to 7 percent of GDP that year.⁷

As one would expect, per capita Medicare spending increases as beneficiaries age. For example, in 2006, per capita Medicare spending for beneficiaries in the traditional fee-for-service program who were age 85 or older totaled \$12,059, more than double the \$5,887 average for beneficiaries ages 65 to 74.⁸ As the baby boom generation ages into Medicare, however, the age mix of the program’s beneficiaries will initially be younger than it is today. Only after 2030, when the bulk of baby boomer beneficiaries reach an older age level, is age mix expected to contribute more to program spending than it does now.⁹

Unique Medicare Policy Issues

Certain policy issues unique to the Medicare program have significantly affected program spending and projections. For example, addition of the Medicare Part D prescription drug benefit in 2006 increased program outlays considerably, accounting for two-thirds of the \$72 billion increase from 2005 to 2006. Additionally, in recent years rising enrollment of Medicare beneficiaries into private Medicare Advantage (MA) plans increased program expenditures because the average per enrollee payments made to these private plans has exceeded the cost of the traditional fee-for-service program. These payments in excess of the cost of the Medicare fee-for-service program averaged 13 percent in 2010.¹⁰ As a result of recent policy changes that reduced payments to MA plans, MA plan enrollment is projected to decline in the future.¹¹

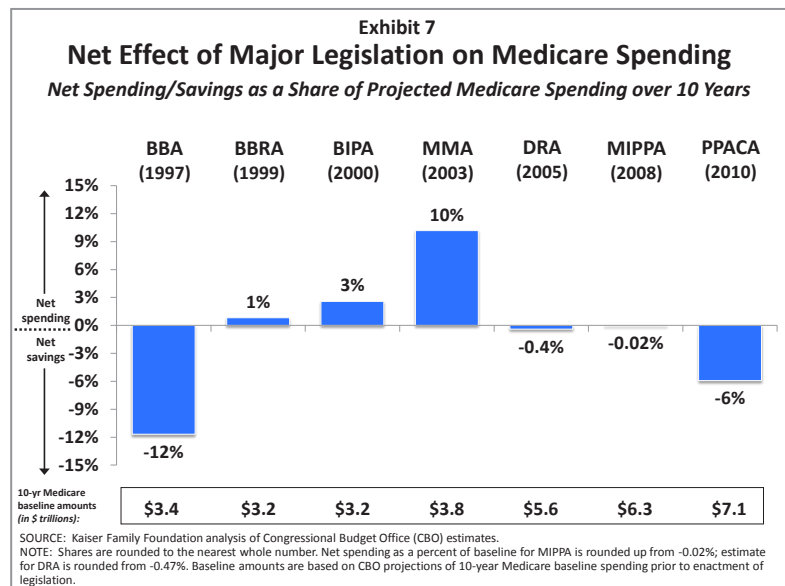
Administrative Costs

The costs of administering the Medicare program have remained low over the years – less than 2 percent of program expenditures. As such, program administration is not a contributing factor to Medicare’s expenditure growth. Administrative costs include all expenses by government agencies in administering the program (HHS, Treasury, the Social Security Administration, and the Medicare Payment Advisory Commission). Also included are the cost of claims contractors and other costs incurred in the payment of benefits, collection of Medicare taxes, fraud and abuse control activities, various demonstration projects, and building costs associated with program administration.

HOW WILL HEALTH REFORM AFFECT MEDICARE SPENDING?

Implementation of the Patient Protection and Affordable Care Act (ACA) of 2010 will have a major effect on Medicare spending and policy.¹² Most of the Medicare provisions in the ACA will reduce program spending, but some will increase it, and on net, Medicare spending will be reduced by an estimated \$424 billion for the 10-year period from fiscal year 2010 through fiscal year 2019, a 6 percent reduction from spending that had been projected for that period (**Exhibit 7**).¹³ While this amount is not insignificant, it is also not unprecedented, and represents a smaller share of projected 10-year baseline Medicare spending than the spending reductions included in the Balanced Budget Act (BBA) of 1997. At the time it was enacted, the BBA was projected to result in a 12 percent reduction in projected baseline Medicare spending.¹⁴

The ACA includes a number of provisions that are expected to reduce Medicare spending. (See Appendix A for the cost estimate for the major Medicare provisions in the ACA.)



Reduced Payments to Providers and Medicare Advantage Plans

More than half the Medicare savings comes from two provisions: one that institutes a productivity adjustment which will reduce annual fee-for-service provider payment updates and one that makes changes to payments for Medicare Advantage plans. Additional savings come from reducing payments for preventable hospital readmissions and home health services. The annual increase in payment rates for various Medicare services, generally adjusted to reflect inflation, will be reduced by a measure of economy-wide productivity improvement. The compounding effect of this change will significantly reduce growth in program spending in perpetuity. The Medicare actuaries have questioned whether the savings will be sustainable for the long run, while others believe the baseline sets a new achievable target for promoting provider efficiency.¹⁵

For Medicare Advantage plans, the ACA phases out payments made in excess of fee-for-service costs, consistent with recommendations of the Medicare Payment Advisory Commission. In addition, the

productivity adjustment and other Medicare fee-for-service payment changes generate additional savings from MA plans because plan payments are linked to fee-for-service spending levels.

Independent Payment Advisory Board (IPAB)

The newly-created IPAB is a 15-member panel charged with recommending a set of Medicare program changes, within certain constraints, if program spending growth exceeds specified targets, beginning in 2015. These targets are estimated to require IPAB to identify nearly \$16 billion in savings for the years 2015 to 2019. The IPAB recommendations will be sent to the Congress under special procedures; disapproval will require a supermajority vote. They may not include changes to increase revenues, beneficiary premiums or cost-sharing; restrict benefits or modify eligibility criteria. Prior to 2019, certain providers are exempt from reductions.

Beneficiary Premiums

The ACA modified a provision in current law that requires higher-income Medicare Part B enrollees to pay a higher monthly Part B premium. The law temporarily eliminates the indexing of the income thresholds at which the higher premium must be paid. As a result, between 2010 and 2019, the share of Medicare beneficiaries paying an income-related Part B premium will rise from 5 percent to 14 percent.¹⁶ In addition, the law established a new income-related premium for Medicare beneficiaries enrolled in Part D prescription drug plans, reducing government contributions for Part D coverage by increasing premiums for higher-income beneficiaries who are also subject to the income-related Part B premium. The thresholds for the Part B and Part D income-related premium are fixed at \$85,000 for an individual beneficiary and \$170,000 for couples through 2019.

Delivery System Reforms

Other provisions of the ACA are aimed at changing the health care delivery system in ways that seek to produce long-run efficiencies and program savings. A general theme of these provisions is to shift provider incentives away from increasing the volume of services toward incentives for improving quality and care coordination. Examples include establishment of a Medicare Shared Savings program for Accountable Care Organizations (ACOs) and bundling payments around a hospital stay. A new Center for Medicare and Medicaid Innovation will test additional innovative payment and service delivery models, a number of which are expected to focus on Medicare and Medicaid dual eligibles and other high-need populations.

Other Provisions That Increase Medicare Spending

Some provisions will increase program spending and partially offset the savings generated from the provisions discussed above. Most notably, the law gradually phases in coverage to close the Part D coverage gap (or “doughnut hole”) by 2020. The law also includes an annual wellness visit and other improvements in Medicare coverage of recommended preventive services.

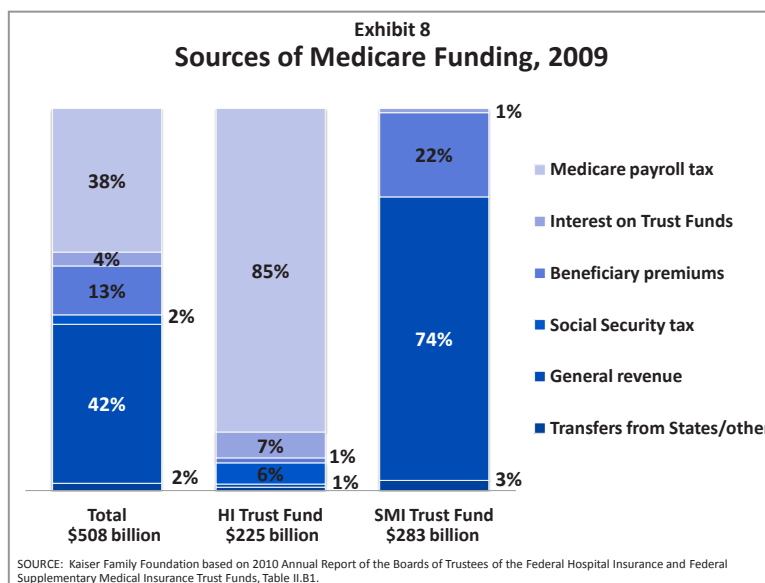
Revenue Provisions

Finally, although not affecting program spending, the law included two provisions that will provide new revenue streams dedicated to financing Medicare benefits. These are an increase in the Medicare payroll tax on certain high earners (earnings more than \$200,000 for an individual or \$250,000 for a couple) and a new fee on drug manufacturers.

HOW IS MEDICARE FINANCED?

In financing Medicare, the government draws from several sources of revenue: a dedicated Medicare payroll tax, general revenue (primarily federal income taxes), premiums collected from beneficiaries, a tax on Social Security benefits, and, since 2006, payments from states for the Medicare drug benefit, which shifted some state Medicaid program expenditures to Medicare (**Exhibit 8**).

Operationally, Medicare financing is conducted through two trust fund accounts. The Hospital Insurance (HI) Trust Fund finances inpatient hospital care and other services covered under Medicare Part A, and the Supplementary Medical Insurance (SMI) Trust Fund finances physician and other services covered under Medicare Part B along with the Part D prescription drug benefit. Both trust funds are used to pay MA plans for providing benefits to their enrollees under Parts A and B and, where applicable, Part D. (*See Appendix B for detail on the sources and uses of Medicare Trust Fund revenue.*)



HI Trust Fund

Medicare payroll taxes and certain other dedicated revenue are credited to the HI Trust Fund. The Medicare payroll tax, requiring contributions of 1.45 percent of wages each from the employer and employee, is a primary source of HI Trust Fund revenue. In 2009, the payroll tax provided 85 percent of all the revenue contributed to the HI Trust Fund and 38 percent of Medicare revenue overall.

In any given year, the revenue dedicated to the HI Trust Fund may be greater or less than the expenditures from the fund. When income exceeds expenditures, the excess HI Trust Fund revenue amounts are loaned to the federal government and used to pay for other federal obligations. Interest on the loans is credited to the Trust Fund as income. Interest payments are not actually transferred out of general revenue unless these amounts are needed to pay Medicare claims. As a result, the amounts collected in Medicare payroll taxes and other dedicated revenue but loaned out of the HI Trust Fund, along with the associated interest payments, represent a claim on future general revenue funds. The HI Trust Fund balance, which totaled \$279 billion at the end of fiscal year 2010, is a measure of these future claims that have accumulated to date, to be drawn upon when payroll taxes and other dedicated revenue are insufficient to cover program obligations.

Supplementary Medical Insurance (SMI) Trust Fund

The SMI Trust Fund is financed primarily through the monthly Part B and Part D premiums paid by beneficiaries and by general revenue. Beginning in 2011, revenue from the new fee on drug manufacturers established by the ACA will be credited to this trust fund. In 2009, general revenue accounted for 74 percent of the SMI Trust Fund revenue and 42 percent of all Medicare revenue, while

total beneficiary premiums made up 22 percent of the SMI Trust Fund revenue and 13 percent of Medicare revenue overall.

Unlike the HI Trust Fund, SMI Trust Fund financing is not structured in a way that will produce yearly excess revenue or shortfalls. In this case, beneficiary premiums and general revenue contributions are adjusted each year in order to cover trust fund obligations.

HOW IS MEDICARE'S FISCAL STATUS MEASURED?

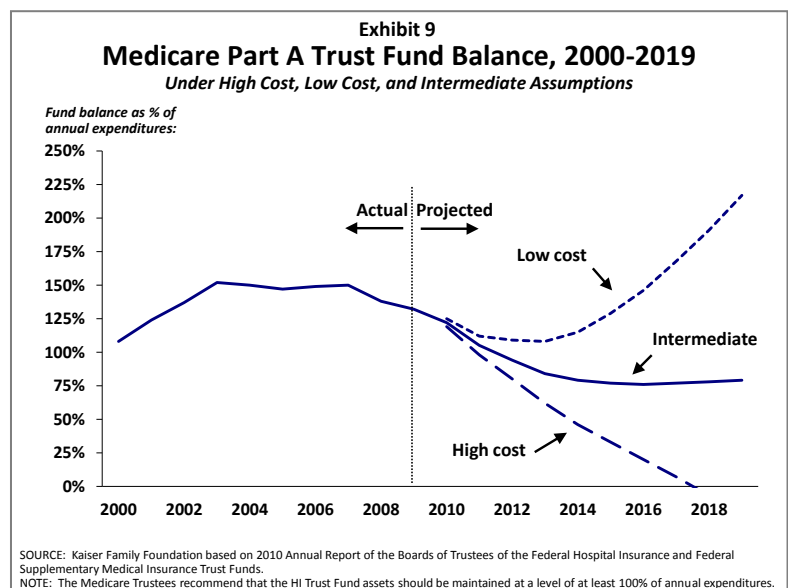
Serious concerns have been raised about the long-term financial health of the Medicare program. The program's financial status is often measured in terms of the HI Trust Fund solvency or Medicare spending as a share of the federal budget and of the overall national economy. New benchmarks were established under the ACA for purposes of determining whether IPAB will need to recommend changes to the Medicare program in order to achieve specified levels of savings. Each measure addresses a different perspective on the program's financing and points toward different potential solutions to Medicare's long-term financing challenges.

Because economic forecasts and estimates of Medicare and total federal spending are always being adjusted due to changes in forecasts and better information, it is difficult to isolate the effects of the ACA from other factors affecting Medicare's fiscal status. For the measures discussed here, where possible, using the information available when the law was passed, a sense of the order of magnitude of the effects of the ACA is included.

Trust Fund Solvency

Solvency of the HI Trust Fund is the measure of Medicare's financial health that typically receives the most attention (**Exhibit 9**). A report on the financial status of the HI Trust Fund is released annually, as required by law, including short-run and long-run financial forecasts prepared by the Medicare actuaries. The report is issued by the Medicare Trustees, an oversight panel comprised of the Secretaries of Health and Human Services (HHS), Labor, and Treasury; the Commissioner of Social Security; and two public trustees appointed by the President.

The most recent annual report underscores the precarious financial health of the HI Trust Fund.¹⁷ Reflecting the recession's effect on payroll tax contributions, in each year since 2008, total payments from the HI Trust Fund exceeded total income to the Fund. When such a shortfall occurs, the Trust Fund reserves are drawn upon through general revenue transfers to make up the difference. The shortfall was \$17 billion in 2009 and is projected to continue to accumulate for several more years, further drawing down the HI Trust Fund reserves.



Reversing the trend of annual shortfalls, annual surpluses are now expected to occur from 2014 until after 2020 when shortfalls will begin anew and the Trust Fund balances are expected to be exhausted in 2029. The balances are exhausted at the point when even if all the payroll tax amounts that were previously loaned to the rest of the federal government are repaid with interest, the Trust Fund will not have sufficient funds to cover the entire cost of inpatient hospital care and other Medicare Part A services.

The 2029 date is 12 years later than projected prior to enactment of the ACA. The Medicare actuaries and the CBO have each noted, however, that because the ACA included other provisions that will increase federal spending obligations in the future, the fiscal position of the federal government will still be challenged to find the future funding needed to meet program obligations.¹⁸

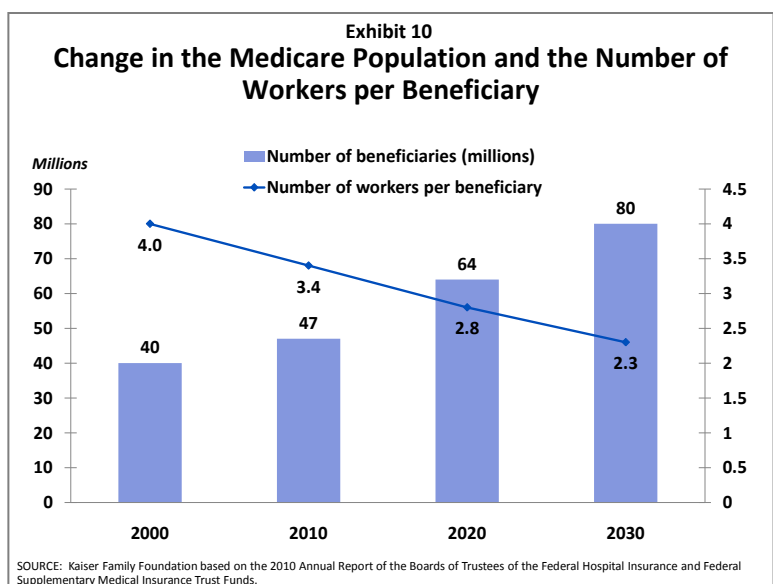
A range around the 2029 insolvency date is bounded by the actuaries' more pessimistic and optimistic assumptions about future economic and demographic factors and health-care costs (shown in Exhibit 9 as "high cost" and "low cost" assumptions). That is, assuming slower economic growth or more rapidly growing health care costs would move up the insolvency date to 2017, while assumptions of faster economic growth and slower growth in use of health services would push back the insolvency beyond the end of the 75-year projection period in 2085.

The projection of HI Trust Fund exhaustion in 2029 does not mean that the Medicare program will be "bankrupt", or that there will be no funds available to pay for Medicare Part A benefits that year, since revenue will continue to flow to the HI Trust Fund. Rather, it means that there will be insufficient funds to meet all the Trust Fund obligations. What makes the problem especially serious, however, is that it is not temporary—the shortfalls in HI benefit financing will continue to accumulate each year unless something changes either to increase the revenue coming into the Trust Fund or to decrease total Trust Fund expenditures. No process currently exists for addressing insufficiencies in the HI Trust Fund; new legislation would be required to make up the difference.

Medicare's per capita spending rate is not the only factor affecting Trust Fund solvency. Demographic factors also are important. Not only will Medicare need to provide for more beneficiaries, but there will also be fewer workers per beneficiary making payroll contributions to help cover the costs (**Exhibit 10**).

In 2010, 3.4 workers were contributing taxes for each beneficiary; by 2030 that figure is projected to fall to 2.3 and continue to decline to 2.1 workers per beneficiary by 2080.¹⁹ As a result, even at a healthy rate of economic growth, Medicare payroll taxes would not keep pace with program growth. This worker-to-retiree ratio problem is not unique to the United States. In fact, the proportional decline in workers is expected to be much worse in Japan and many European countries.²⁰

While technically, the SMI Trust Fund cannot become insolvent, financing the

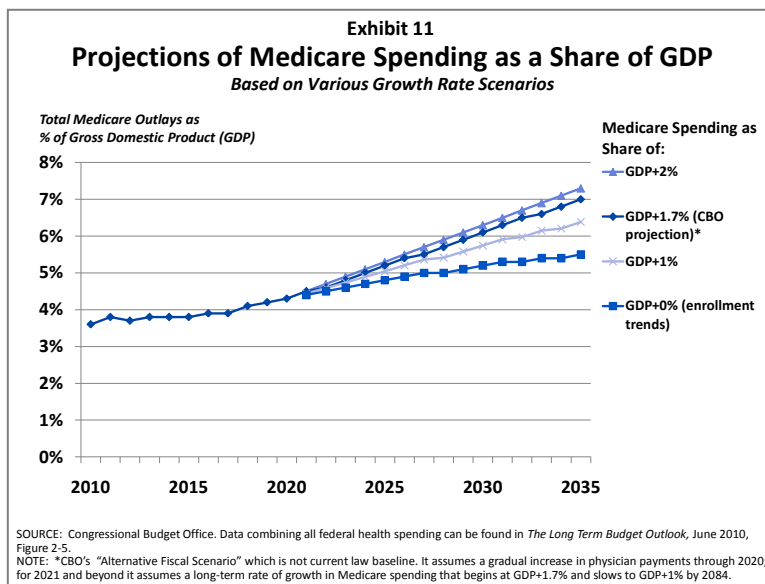


projected growth in spending for Part B and Part D services would require increasing general revenue and beneficiary premium contributions. The increase in general revenue contributions has important implications for the federal budget, which offers another way to measure Medicare financing.

Medicare Spending as a Share of Gross Domestic Product (GDP)

One common way of evaluating the burden of financing a rapidly growing Medicare program is to consider Medicare spending in relation to the overall U.S. economy. While no particular amount of the GDP is the “correct” amount for Medicare spending, the implication of having more economic output devoted to Medicare is that fewer resources are available to meet other needs. As referenced earlier, Medicare spending grew from 2.2 percent of the GDP in 2000 to 3.6 percent of the GDP in 2010, a period covering the addition of the Part D prescription drug benefit. During the coming decade, Medicare spending as a share of GDP is projected to grow at a somewhat slower rate, to about 4 percent by 2020, as the savings provisions in the ACA are implemented.²¹

By 2035, under CBO’s long-term alternative Medicare baseline trend (which differs from current law), Medicare spending will reach 7 percent of GDP.²² This baseline begins with growth in per enrollee spending equal to the 1985-2008 trend of GDP plus 1.7 percentage points, but gradually slows under the assumption that as health care eventually begins to crowd out consumption of other necessary goods and services to a degree that is unsustainable, slower growth in health care costs will result even in the absence of changes in federal law. Substantial savings would result if program expenditures were to grow more slowly. For example, if beginning in 2021, growth in Medicare spending per beneficiary were equal to growth in the GDP plus 1.0 percentage point, by 2035, Medicare spending as a share of GDP would be reduced from about 7 percent to about 6 percent (**Exhibit 11**). (See *Text Box, “Putting Medicare Spending Growth Rate Differentials in Context.”*)



IPAB Benchmarks

The Medicare spending targets under which IPAB will operate represent another measure of Medicare’s fiscal status. The targets are established using five-year averages, and prior to 2018 are based on an average of the increase in the Consumer Price Index (CPI) and the medical care expenditure category of the CPI. Beginning in 2018, the target for Medicare spending per beneficiary is equal to growth in the GDP plus 1.0 percentage point. If spending is determined to exceed the applicable target, IPAB is directed to recommend reductions in program spending up to a limit that begins at 0.5 percent of program expenditures in 2015 and rises to 1.5 percent of program expenditures by 2018. So, although the target provides a limit that triggers action by IPAB, the required savings are not set to constrain total program spending to meet the growth target. The CBO projects Medicare spending will exceed targets in 2015 through 2019.

Putting Medicare Spending Growth Rate Differentials in Context

The difference between an annual growth rate target for per beneficiary Medicare spending of GDP plus 1.0 percentage point referenced by some Medicare savings proposals and the GDP plus 1.7 percentage point trend that CBO assumes as the basis of its long-term projections for the period beginning in 2021 might not seem significant, but it is.

For example, in 2020 CBO projects that Medicare outlays will total about \$950 billion. The one-year difference between a 1.7 percent increase from 2020 (\$16.2 billion) and a 1.0 percent increase (\$9.5 billion), or 0.7 percent, is \$6.7 billion.

The impact of a reduction in Medicare spending based on a lower growth rate compounds over time. For example, if the annual growth in Medicare spending from 2011-2020 were 0.7 percentage points lower than CBO currently projects, the total 10-year spending would be reduced by about \$280 billion, roughly a 4 percent reduction. The impact gets larger as the time horizon extends.

Another perspective is that the GDP is large—about \$24 trillion in 2020 under the CBO projections—so any measurable difference in the size of the Medicare program as a proportion of the GDP will be a large dollar amount. For example, in 2009 the Medicare actuaries projected that by 2020 Medicare would comprise 4.53 percent of GDP. In the 2010 report, after enactment of the ACA, the actuaries' 2020 current law Medicare forecast fell to 3.91 percent of GDP—a decline of 0.62 percent of GDP that translates into a reduction in projected Medicare spending in 2020 of about \$149 billion.

Medicare Spending as a Share of the Federal Budget

As noted earlier, Medicare is one of the largest and fastest growing federal programs. Budget experts have expressed concern about the long-run fiscal implications of the federal obligation for spending on Medicare and other health programs. For example, the National Commission on Fiscal Responsibility and Reform estimated that by 2025, federal revenue will be sufficient only to pay for Medicare, Medicaid, Social Security and interest on the national debt.²³ As a result, recent proposals by this group and others for improving the nation's fiscal status would, among other actions, reduce Medicare spending.

The Medicare Solvency "Trigger"

Another measure of Medicare's claim on the federal budget is commonly referred to as the "45 percent trigger." Implemented as part of the Medicare Modernization Act of 2003, the trigger provision requires the Medicare Trustees to estimate, using a particular formula, a ratio measuring the extent to which program expenditures exceed dedicated revenue. If, for two consecutive years, the actuaries project that the ratio is expected to exceed 45 percent within seven years, a "Medicare funding warning" is issued by the Trustees. The trigger is intended to draw attention to Medicare's financial situation and to prompt the President and Congress to develop a response, but no automatic spending reductions or other changes in the program are set to occur as a result of the warning. The Medicare Trustees have issued a Medicare funding warning each year since 2007. Most recently, in the 2010 annual report, they estimated that the ratio would reach 45 percent in 2010. This is much earlier than previous reports, a change they attribute to the effects of the poor economy on Medicare payroll tax receipts. To date, the Congress has not voted on any legislation offered in direct response to the warning, and this measure has been criticized as arbitrary, and promoting certain policy solutions over others.²⁴

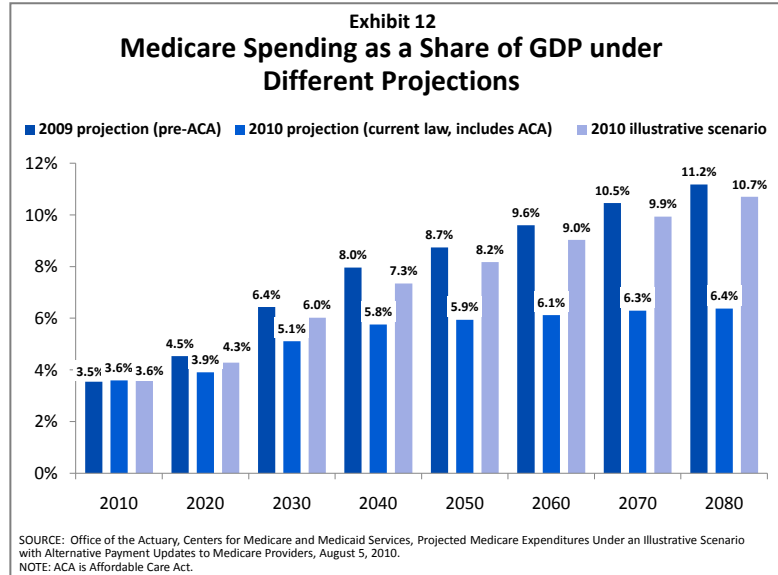
Medicare's Long-Term "Unfunded Obligation"

As part of their long-range analysis of the Hospital Insurance Trust Fund, the Medicare actuaries calculate the 75-year "unfunded obligation", as the present value of future Trust Fund expenditures less future income, decreased by the trust fund balance on hand at the beginning of the projection period. In the most recent estimates from 2010, this totals \$2.4 trillion, an amount dramatically lower than the \$13.4 trillion estimated in 2009, a reduction which is due to the provisions of the ACA. The reduction is largely attributed to the ongoing savings associated with the annual productivity adjustment to the provider payment rate updates.

Uncertainties in Projections

Given the complexity of both the U.S. economy and health care system, Medicare financing projections are always uncertain. They rely on a variety of predictions about the economy, demographics, and health care spending trends. Economic factors affect both spending and revenue projections. For example, future payroll taxes are tied to growth in wages, while annual increases in payments to hospitals and other providers are linked to measures of price inflation. The longer the time horizon under consideration, the greater the uncertainty introduced into the forecasts.

Current projections are perhaps more uncertain than ever, however, because of difficulties in predicting a path for the current economy, uncertainties about the effects of health reform, and indecision about the long-term treatment of physician payments in the Medicare program. The Medicare actuaries, for example, have developed an alternative scenario for Medicare spending that assumes the physician payment cuts required under current law will not take effect, with physician fees instead updated annually by the Medicare Economic Index.²⁵ It also assumes that the productivity adjustment will prove unsustainable and will be phased out over 15 years beginning in 2020. Under this alternative scenario, the HI Trust Fund would be exhausted in 2028, only one year earlier than projected, but the long-run implications for HI spending obligations would be much greater when measured as a percent of taxable payroll or share of GDP.²⁶ Long-run total Medicare spending as a share of GDP would remain lower than predicted in the 2009 Trustees Report, but would be much higher than the current law forecasts. For example, in 2030, Medicare would represent 6 percent of GDP, compared with 5 percent projected under current law in the 2010 Trustees report (**Exhibit 12**).



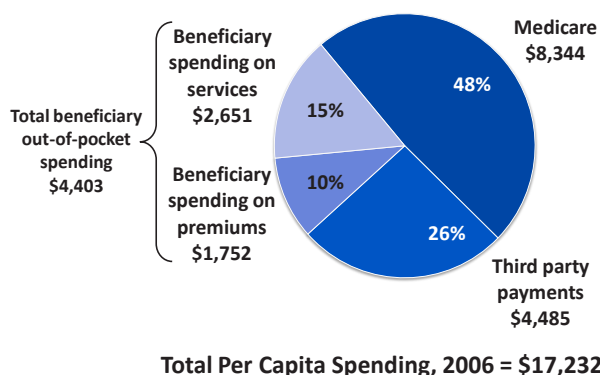
HOW DOES THE RISING COST OF MEDICARE AFFECT BENEFICIARIES?

In addition to monthly premiums, Medicare beneficiaries contribute to the cost of their care through cost sharing at the point of service—for example, Medicare deductibles and coinsurance—which are not reflected in data on Medicare spending or financing. For 2011, the standard monthly Part B premium is \$115.40, with higher-income beneficiaries paying as much as \$369.10 per month.²⁷ Part D premiums vary depending on the private plan chosen, but average about \$30 a month.²⁸ In addition, beneficiaries face a \$1,132 deductible for Part A inpatient hospital services, a \$162 deductible for services covered under Part B, a 20 percent coinsurance for many services covered by Part B, and, in some cases, an additional amount for physician services, known as “balance billing” amounts. Medicare beneficiaries also pay for health care items and services not covered by Medicare, including most vision, dental, and hearing services and long-term care.

Overall, Medicare paid 48 percent of beneficiaries’ total medical and long-term care costs in 2006; beneficiaries paid 15 percent of the total for Medicare-covered and other services and another 10 percent for premiums for Part B and supplemental insurance; and third-party payers (Medicaid, private supplemental “Medigap” plans, and employer-sponsored health plans) paid 26 percent of the total on behalf of beneficiaries (**Exhibit 13**).

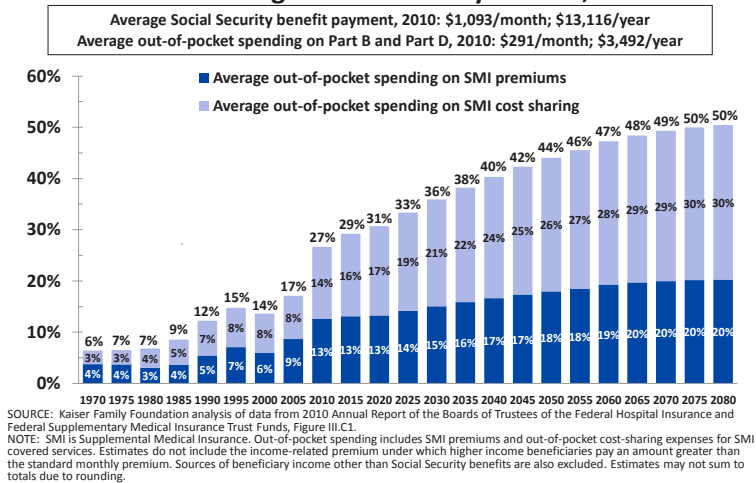
Because of premium and cost-sharing requirements, the growing cost of Medicare creates a financial burden on beneficiaries as well as the federal government. The Medicare Trustees project that over time beneficiaries will pay an increasing share of their Social Security income for their Medicare coverage. In 2010, premiums and cost-sharing for Part B and Part D together accounted for 27 percent of the average Social Security benefit (premiums accounted for 13 percent and average cost sharing absorbed another 14 percent). By 2030, Medicare premiums and cost sharing for Parts B and D are estimated to grow to 36 percent of average Social Security benefits (**Exhibit 14**).²⁹ Additionally, beneficiaries will face rising premiums for private Medicare supplemental coverage. The impact on

Exhibit 13
Sources of Payment for Health Care Services to Medicare Beneficiaries, 2006



SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use file, 2006.
NOTE: Excludes Medicare Advantage enrollees.

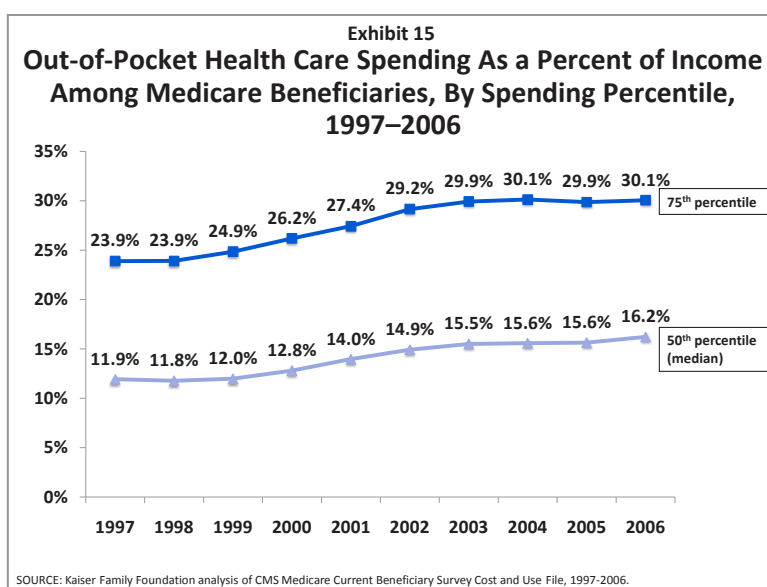
Exhibit 14
Total Part B and Part D (SMI) Out-of-Pocket Spending as a Share of the Average Social Security Benefit, 1967-2084



individual beneficiaries will vary—those who use fewer health services may be less affected by cost-sharing requirements and those with higher incomes may be better able to afford to pay more for their Medicare benefits.

Assistance is provided to the lowest-income Medicare beneficiaries through federal subsidies for Part D premiums and through the Medicare Savings Programs which provide Medicaid subsidies for Part B premiums and in some instances, Medicare cost sharing.³⁰ However, many low-income Medicare beneficiaries do not have Medicaid coverage: more than one-third of Medicare beneficiaries with incomes below 100 percent of the federal poverty level do not have Medicaid coverage and two-thirds of those with incomes between 100 and 150 percent of poverty do not have Medicaid coverage.³¹ In addition, some beneficiaries may be shielded from premium increases due to a provision in law known as the “hold harmless,” which caps the Part B premium increase to prevent monthly Social Security income from falling as the Part B premium increases. The hold-harmless provision does not apply to Part D premiums.

Most beneficiaries are not protected against increases in Medicare’s cost-sharing amounts, however. Coinsurance amounts rise annually along with provider payment rates. With health costs rising faster than income for Medicare beneficiaries, median out-of-pocket health spending as a share of beneficiaries’ income increased from 11.9 percent in 1997 to 16.2 percent in 2006; among the top quartile of beneficiaries, out-of-pocket health care costs as a share of income rose to 30 percent or more by 2006 (**Exhibit 15**).



WHAT IS THE OUTLOOK FOR THE FUTURE?

Policymakers are always challenged to balance the interests of Medicare beneficiaries, taxpayers, health care providers and manufacturers, but national economic and fiscal constraints in the near term will make the task more difficult than ever. Rising costs of health care pose similar challenges to all payers—employers and individuals as well as Medicare and other government programs.

The long-run fate of Medicare depends on solving the larger problem of rising health care costs. The Affordable Care Act of 2010 takes initial steps to use Medicare’s leverage to carve a path that slows cost growth and improves quality, but it will take a sustained effort to play out all the changes required to rein in rising health care costs. There appears to be a consensus among policymakers and stakeholders that Medicare price reductions alone will not work; some set of delivery system reforms will also need to take hold. Further, to address the long-term financing challenges of the HI Trust Fund, and to meet the needs of an aging population, additional revenues will be needed to forestall major Medicare benefit reductions or relatively drastic reductions in provider payments.

Because of Medicare's size, policymakers must also consider the broader effects of changes made to the program. Major reductions in Medicare payments to providers could put upward pressure on the prices they charge to private payers or negatively impact beneficiary access to services. Additional payments to teaching hospitals and those located in rural areas and serving low-income urban populations are explicitly made to address social needs beyond the care of Medicare patients, and substantially reducing or eliminating these payments would disadvantage the communities that rely on these facilities. Raising costs for Medicare beneficiaries would alleviate fiscal pressure for the government, but shift the burden to beneficiaries—many of whom have modest incomes—and reduce their access to needed health services.

At least for the foreseeable future, Medicare policy will be shaped as much by concerns about the size of the federal budget deficit and national debt as by concerns about the program's financial sustainability. The budget deficit is expected to reach nearly \$1.5 trillion in 2011, or 10 percent of GDP, and the publicly-held national debt of \$10 trillion will continue to grow as large deficits are projected for many years to come, even as the health of the economy improves.³² Because Medicare represents a large share of federal spending and is growing faster than other parts of the federal budget, changes to Medicare will inevitably be a focus of deficit reduction debates. Many of the Medicare proposals put on the table as part of broader deficit reduction recommendations are variations on recurring themes. These include introducing caps on Medicare spending growth, increasing beneficiary contributions, reducing provider payments, delaying the age of Medicare eligibility, raising dedicated revenue, expanding the scope of the IPAB, and completely restructuring the Medicare entitlement—each of which could have significant implications for beneficiaries and providers.

The nature of the proposals being offered underscores the scale of changes that may be in store for the Medicare program in the future. The potential effects of these changes on Medicare beneficiaries and providers of care mean that debate over these changes will be contentious. Policymakers will face the difficult challenge of finding cost-reducing strategies that sustain or improve quality of care, and possibly new sources of revenue as well, while balancing the needs of beneficiaries, taxpayers, and health care providers.

APPENDIX A:
**MEDICARE SAVINGS AND SPENDING IN THE PATIENT PROTECTION AND
AFFORDABLE CARE ACT (P.L. 111-148), AS AMENDED BY THE HEALTH CARE
AND EDUCATION RECONCILIATION ACT OF 2010 (P.L. 111-152)**

MEDICARE SAVINGS PROVISIONS	COST ESTIMATE (in \$ billions)
Annual provider payment updates	\$157
Medicare Advantage payment reforms	\$136
Other Medicare Advantage plan savings (<i>interactions with fee-for-service savings</i>)	\$70
Home health payments	\$40
Part B premiums for higher-income enrollees	\$25
Disproportionate Share Hospital (DSH) payments	\$22
Medicare Improvement Fund	\$21
Independent Payment Advisory Board	\$16
Part D premiums for higher-income enrollees	\$11
Fraud, waste, and abuse	\$7
Reducing hospital readmissions	\$7
Part D enrollment and other consumer protections	\$6
Delivery system pilot programs	\$5
Other provisions	\$7
TOTAL 10-YEAR GROSS MEDICARE SAVINGS	\$528
MEDICARE SPENDING PROVISIONS	
Part D coverage gap discount program and new federal subsidies	\$43
Premium reductions (<i>interactions with fee-for-service savings</i>)	\$38
Physician payment reforms	\$7
Preventive services	\$5
Other provider payments	\$1
Medicare Savings Programs and Part D low-income subsidies	\$1
Disproportionate Share Hospital (DSH) payments	\$1
Part D enrollment and other consumer protections	\$1
Medicare Advantage reforms	\$1
Other provisions	\$4
Interactions*	\$2
TOTAL 10-YEAR GROSS MEDICARE SPENDING	\$104
NET 10-YEAR MEDICARE SAVINGS	\$424
OTHER RELATED REVENUE PROVISIONS	
Raise Medicare payroll tax on high earnings (Deposited in HI Trust Fund)	\$87
Fee on drug manufacturers (Deposited in SMI trust fund)	\$27
Eliminate Part D employer deduction	\$5

NOTE: *Spending interactions include implementation of Medicare changes, Part D interactions with Medicare Advantage provisions, and Part B interactions with Part D provisions.

SOURCE: Kaiser Family Foundation analysis of Congressional Budget Office (CBO) cost estimates as provided on March 20, 2010; Revenue estimates based on Joint Committee on Taxation estimates as provided on March 20, 2010.

APPENDIX B: MEDICARE'S TRUST FUNDS

	Hospital Insurance (HI) Trust Fund	Supplementary Medical Insurance (SMI) Trust Fund
Sources of Funds	<p>The HI Trust Fund is the repository for the Medicare payroll tax contributions (1.45 percent each for employee and employer), which constituted 85 percent of Trust Fund revenue in 2009.</p> <p>Other sources of funding include some of the income taxes paid on Social Security benefits by those exceeding certain income thresholds (6 percent of revenue); interest earned on trust fund balances (7 percent), and enrollee premiums (1 percent).</p>	<p>Premiums paid by beneficiaries constituted 22 percent of SMI Trust Fund revenue in 2009. General revenue contributed 74 percent of the total; transfers from states to offset state savings from implementation of the Medicare drug benefit accounted for 3 percent; interest on the Trust Fund balance was 1 percent.</p> <p>Beneficiary premiums include the standard monthly premium paid for Medicare Part B (\$115.40 in 2011); premiums paid by beneficiaries electing to enroll in Medicare Part D for their prescription drug coverage, which vary based on the plan they choose; and beginning in 2007, an income-related Part B premium paid by higher income beneficiaries. In 2011, the thresholds are \$85,000 individual/\$170,000 couple; these amounts are fixed through 2019. The total premium paid by these beneficiaries ranges from 40 percent to 220 percent higher than the standard premium, depending on income.</p>
Use of Funds	<p>Medicare Part A benefits are financed out of the HI Trust Fund. Individuals become eligible for Medicare Part A when they turn age 65 if they have made sufficient payroll tax contributions or choose to pay a premium to enroll; disabled individuals and those with end-stage renal disease may qualify at a younger age.</p> <p>Part A benefits include inpatient hospital care (55 percent of net HI expenditures for health services in 2009); limited skilled nursing facility</p>	<p>The SMI Trust Fund is used to pay for benefits under Medicare Part B and to pay premiums to private prescription drug plans under Medicare Part D. Unlike Part A, eligible individuals must elect to enroll in Medicare Parts B and D and pay a monthly premium.</p> <p>Part D benefits in 2009 accounted for 23 percent of all SMI expenditures.</p> <p>Part B benefits include physician care (23 percent of SMI expenditures in 2009); outpatient hospital services (11 percent); and home health care (4</p>

	Hospital Insurance (HI) Trust Fund	Supplementary Medical Insurance (SMI) Trust Fund
	<p>care (11 percent), home health (3 percent) and hospice (5 percent). Some 24 percent of payments from the HI Trust Fund are made to cover the costs of services to beneficiaries enrolled in private Medicare Advantage plans.</p> <p>The remaining 1 percent of expenditures pays for Medicare program administration, including government costs incurred in the payment of benefits, collection of taxes, fraud and abuse control activities, and various demonstration projects.</p>	<p>percent). About 20 percent of payments from the SMI Trust Fund are made to cover the costs of services to beneficiaries enrolled in private Medicare Advantage plans. When combined, other benefits, including durable medical equipment, laboratory and ambulance services, clinic care and other services, account for about 17 percent of SMI expenditures.</p> <p>The remaining 1 percent of expenditures pays for Medicare program administration, including government costs incurred in the payment of benefits, collection of taxes, fraud and abuse control activities, and various demonstration projects.</p>
Financial Status	<p>The financial status of the HI Trust Fund depends on the extent to which the Medicare payroll tax and other revenue that is dedicated to the Trust Fund covers the Part A expenditures that are obligated to be financed by the fund. At the end of calendar year 2009, the HI Trust Fund had a balance of \$304 billion. Over the next decade the Trust Fund is projected to have sufficient income to cover expenditures each year; over the longer term, however, the Medicare actuaries project that the trust fund balances will be exhausted and therefore there will be insufficient funds to pay all obligations beginning in 2029, under the Medicare actuaries' intermediate (most likely) assumptions.</p>	<p>The Part B premium is set each year to cover 25 percent of the projected cost of Part B benefits. Similarly, the Part D premium is set by statute to cover 25 percent of the projected cost of Part D benefits. General revenue funds are drawn to cover the balance of SMI Trust Fund expenditures.</p> <p>Because of the annual recalculation of premiums and the automatic draw on general revenue, the SMI Trust Fund technically cannot be in shortfall.</p>

SOURCE: 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, August 5, 2010.

ENDNOTES

¹ One in five dollars from Centers for Medicare and Medicaid Services, Office of the Actuary, *National Health Expenditures by Type of Service and Source of Funds: Calendar Years 1960-2008*, http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp
Data on hospital stays from Agency for Health Care Research and Quality, Health Cost and Utilization Project <http://hcupnet.ahrq.gov/>

² Congressional Budget Office, *Monthly Budget Review*, October 2010, and US Treasury, *Final Monthly Treasury Statement for Fiscal Year 2010*, September 2010.

³ Between FY 2011 and FY 2021, CBO projects GDP to grow by 4.5 percent, inflation to grow by 2 percent, and Medicare per capita spending to grow by 3 percent. Congressional Budget Office, *Budget and Economic Outlook*, January 2011.

⁴ Centers for Medicare and Medicaid Services, Office of the Actuary Memorandum, *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers*, Table 3, August 5, 2010; and 2010 Annual Report of the Medicare Trustees, Table III.A1.

⁵ Centers for Medicare and Medicaid Services, National Health Expenditure Data, including September 2010 projections. https://www.cms.gov/NationalHealthExpendData/01_Overview.asp#TopOfPage

⁶ 2010 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds, Table III.A3.

⁷ Congressional Budget Office. Trend data combining all federal health spending as a share of GDP can be found in *The Long Term Budget Outlook*, June 2010, Figure 2-5.

⁸ Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use file, 2006.

⁹ Hartman, Micah and others, *U.S. Health Spending By Age, Selected Years Through 2004*, Health Affairs Web Exclusive, November 6, 2007.

¹⁰ Medicare Payment Advisory Commission, *Medicare Payment Policy*, March 2010.

¹¹ 2010 Annual Report of the Boards of Trustees, Table III.A3 and p. 49.

¹² The Patient Protection and Affordable Care Act (P. L. 111-148) and the Health Care and Education Reconciliation Act which amended it (P.L. 111-152) are collectively referred to as the Affordable Care Act (ACA).

¹³ Kaiser Family Foundation estimates using Congressional Budget Office, Letter to Speaker Pelosi, March 20, 2010 and "CBO's March 2009 Baseline: Medicare". See

<http://cbo.gov/publications/collections/collections.cfm?collect=10>

¹⁴ Kaiser Family Foundation, *Medicare Savings in Perspective: A Comparison of 2009 Health Reform Legislation and Other Laws in the Last 15 Years*, December 2009.

¹⁵ Centers for Medicare and Medicaid Services, Office of the Actuary, *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers*, Memorandum, August 5, 2010 and Merlis, Mark. "Adding up the Numbers, Understanding Medicare Savings in the Affordable Care Act," Center for American Progress, September 2010.

¹⁶ Kaiser Family Foundation, *Income-Relating Medicare Part B and Part D Premiums: How Many Medicare Beneficiaries Will Be Affected?* December 2010.

¹⁷ 2010 Annual Report of the Boards of Trustees.

¹⁸ Congressional Budget Office, Letter to Senator Session, January 22, 2010; CMS Office of the Actuary, *Estimated effects of the Patient Protection and Affordable Care Act as Amended on the Year of Exhaustion of the Part A Trust Fund, Part B Premium, and Part A and B Coinsurance Amounts*, April 22, 2010.

¹⁹ 2010 Annual Report of the Trustees, p. 78.

²⁰ Organisation for Economic Co-operation and Development, Old Age Dependency Ratio in 2050, Data Chart GE2.1A, <http://www.oecd.org/dataoecd/34/28/34542290.xls>

²¹ The Congressional Budget Office and the Medicare actuaries both project Medicare to be about 4 percent of GDP in 2020. See Congressional Budget Office, *Budget and Economic Outlook*, August 2010 and February 2011 and *The Long-Term Budget Outlook*, June 2010 and the Centers for Medicare and Medicaid Services, Office of the Actuary, *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers*, Memorandum, August 5, 2010.

²² Congressional Budget Office. Data on Medicare and Medicaid combined are included in *The Long-Term Budget Outlook*, June 2010. See pp 36-37 for a discussion of the alternative fiscal scenario for Medicare, which assumes physician fees will increase instead of the reductions scheduled under current law and that after 2020 the ACA productivity adjustment and IPAB provisions will no longer be in effect.

²³ The National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010.

²⁴ Moon, M. *The Policy Implications of Medicare's New Measure of Financial Health*, Kaiser Family Foundation, October 2005, <http://www.kff.org/medicare/upload/7414.pdf>.

²⁵ The Medicare Economic Index measures changes in the prices of goods and services used in operating a physician practice, including items such as salaries, benefits, liability insurance, and office expenses. The salary and wage components are adjusted to reflect changes in economy-wide productivity.

²⁶ Centers for Medicare and Medicaid Services, Office of the Actuary, *Projected Medicare Expenditures under an Illustrative Scenario with Alternative Payment Updates to Medicare Providers*, Memorandum, August 5, 2010.

²⁷ In both 2010 and 2011, hold harmless protections left the Part B premium unchanged for most Medicare beneficiaries, at \$96.40 or \$110.50. New enrollees in 2011 pay the standard \$115.40; higher-income beneficiaries are not held-harmless from premium increases. For more information see, Kaiser Family Foundation, *The Social Security COLA and Medicare Part B Premium: Questions, Answers, and Issues*, December 2010.

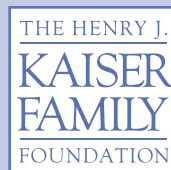
²⁸ \$30 average amount from CMS, *Medicare Advantage Premiums Fall, Enrollment Rises, Benefits Similar Compared to 2010*, September 21, 2010. This amount includes premiums only for basic Part D coverage offered by both stand-alone prescription drug plans (PDPs) and Medicare Advantage drug plans. The average monthly premium for PDPs only, both basic and enhanced plans, is \$40.72 in 2011, weighted by 2010 enrollment, assuming beneficiaries remain in their current plan. Hoadley et al, *Medicare Part D Spotlight: Part D Plan Availability in 2011 and Key Changes Since 2006*, Kaiser Family Foundation, October 2010.

²⁹ Estimates do not include the income-related premium under which higher income beneficiaries pay an amount greater than the standard monthly premium. Sources of beneficiary income other than Social Security benefits are also excluded.

³⁰ For background on Medicare subsidies, see Nemore, P., and others. *Toward Making Medicare Work for Low-Income Beneficiaries: A Baseline Comparison of the Part D Low-Income Subsidy and Medicare Savings Programs Eligibility and Enrollment Rules*, Kaiser Family Foundation, May 2006.

³¹ Kaiser Family Foundation. *The Role of Medicare for the People Dually Eligible for Medicare and Medicaid*. January 2011.

³² Congressional Budget Office, January 2011.



The Henry J. Kaiser Family Foundation

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

www.kff.org

This report (#7731-03) is available on the Kaiser Family Foundation's website at www.kff.org.

The Kaiser Family Foundation is a non-profit private operating foundation, based in Menlo Park, California, dedicated to producing and communicating the best possible analysis and information on health issues.